

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/06/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/23/2010
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NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408
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F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 164	<p>F tag: 164</p> <p>1. <b>Corrective action:</b> Resident # 3, #7, #8--Nurse aides and licensed nursing staff re-educated on resident privacy and dignity to include closing doors, window blinds and privacy curtains while providing care. Inservices on dignity and privacy were conducted for Nursing Department and all staff 8-10 thru 8-15-2010. Education was presented by DON and Compliance Nurses. (See Appendix Item 1 and 1A)</p> <p>2. <b>ID of others at risk:</b> All residents potentially effected, however, no others identified in compliance rounds conducted by Compliance Nurses and DON on 8-10-2010 including specifically Checking for dignity and privacy issues.</p> <p>3. <b>Prevention measures:</b> Inservices on dignity and privacy were conducted for Nursing Department and all staff 8-10 thru 8-15-2010. Education was Presented by DON and Compliance Nurses.</p> <p>Dignity and privacy check added to Compliance Nurse's daily Compliance Rounds Monitor Sheet designed by Nurse Consultant and implemented</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Margaret B. Curtis*

DATE

*Administrators* 8-13-10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	<p>Continued From page 1</p> <p>Based on observations, interviews and record reviews, it was determined the facility failed to ensure three residents (#3, #7 &amp; #8), in the selected sample of 15, had the right to privacy and confidentiality.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #3 was admitted to the facility, on 12/04/08, with diagnoses which included Dementia with Behavior Disturbance, Depression, Cardiopulmonary Disease, Coronary Artery Disease and Hypertension. A review of a quarterly Minimum Data Set (MDS) assessment, dated 06/04/10, revealed the facility identified Resident #3 as severely cognitively impaired and requiring extensive assistance of one staff member with hygiene/bathing and required assistance of two staff members with dressing.</p> <p>An observation, on 07/22/10 at 2:40 PM, revealed Resident #3 was sitting in a shower chair in his/her room and was partially undressed and partially covered with a sheet. A staff member was observed kneeling down in front of the resident and was talking to the resident. The door to the resident's room was open and a resident of the opposite sex walked by and then stopped at the doorway briefly, looking inside the room. The resident proceeded to walk up the hallway after a couple of minutes.</p> <p>An interview with Nurse Aide State Registered (NASR) #12, on 07/22/10 at 4:20 PM, revealed she gave the resident a shower and failed to provide complete privacy in the resident's room. She stated, "I had just taken (the resident) back to the room and was waiting for assistance from another staff member." She further stated that</p>	F 164	<p><b>F tag 164 Continued</b></p> <p>on 8-10-10 Monitor was initiated after review with Compliance Nurses by DON in Daily Team Meeting. Any issues identified in rounds will be corrected, documented, and DON notified. <i>(See Appendix Item 1B)</i></p> <p><b>4. Monitor:</b> Resident privacy and confidentiality will be monitored daily on the Compliance Nurse rounds and will be monitored monthly x 12 months thru the CQI Committee. Any problems noted are to be corrected immediately by the Compliance Nurse. <i>(See Appendix Item 1C)</i></p> <p><b>5. Date Corrected:</b></p>	8-15-10

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F 164	<p>Continued From page 2</p> <p>the resident should have been covered completely and the door closed.</p> <p>2. Record review revealed Resident #7 was admitted to the facility with diagnoses which included Dementia with Behavior Disturbance, Depression, and Hypertension. A review of the significant change MDS, dated 06/15/10, revealed the facility assessed the resident was severely cognitively impaired and required extensive assistance of one staff member with dressing.</p> <p>An observation, on 07/20/10 at 6:30 AM, revealed NASR #5 assisted Resident #7 with getting dressed in the resident's room. NASR #5 did not pull the privacy curtain around the resident, who was observed lying in bed wearing an incontinent brief. NASR #5 pulled the curtain partially after the surveyor entered the room; however, the resident could be seen by anyone entering the room.</p> <p>An interview with NASR #5, on 07/23/10 at 9:02 AM, revealed she did not provide the resident complete privacy and stated, "I should have had the curtain pulled around the resident when I was getting him/her dressed". She stated she forgot to pull the privacy curtain before assisting the resident.</p> <p>3. A record review revealed Resident #8 was admitted to the facility with diagnoses which included Cerebral Vascular Accident (CVA/Stroke) with left side hemiplegia (paralysis), Seizure Disorder, and Parkinson's Disease.</p> <p>A review of the annual MDS, dated 04/01/10, revealed the facility assessed Resident #8 was moderately impaired with decision making and</p>	F 164		

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F 164	<p>Continued From page 2</p> <p>the resident should have been covered completely and the door closed.</p> <p>2. Record review revealed Resident #7 was admitted to the facility with diagnoses which included Dementia with Behavior Disturbance, Depression, and Hypertension. A review of the significant change MDS, dated 06/15/10, revealed the facility assessed the resident was severely cognitively impaired and required extensive assistance of one staff member with dressing.</p> <p>An observation, on 07/20/10 at 6:30 AM, revealed NASR #5 assisted Resident #7 with getting dressed in the resident's room. NASR #5 did not pull the privacy curtain around the resident, who was observed lying in bed wearing an incontinent brief. NASR #5 pulled the curtain partially after the surveyor entered the room; however, the resident could be seen by anyone entering the room.</p> <p>An interview with NASR #5, on 07/23/10 at 9:02 AM, revealed she did not provide the resident complete privacy and stated, "I should have had the curtain pulled around the resident when I was getting him/her dressed". She stated she forgot to pull the privacy curtain before assisting the resident.</p> <p>3. A record review revealed Resident #8 was admitted to the facility with diagnoses which included Cerebral Vascular Accident (CVA/Stroke) with left side hemiplegia (paralysis), Seizure Disorder, and Parkinson's Disease.</p> <p>A review of the annual MDS, dated 04/01/10, revealed the facility assessed Resident #8 was moderately impaired with decision making and</p>	F 164		
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F 164	Continued From page 3 requiring staff assistance with toileting, bathing, dressing and hygiene. The facility identified Resident #8 as incontinent of bowel and bladder and the resident wore a brief.  An observation, on 07/22/10 at 1:35 PM, revealed RN #1 and NASR #2 transferred Resident #8 to bed and provided incontinent care and completed a skin audit and did not completely close the door to the room. The staff did not pull the privacy curtain or close the window blind, during incontinent care. The resident's roommate was present in the room and asleep on the next bed.  An interview with RN #1, on 07/22/10 at 2:00 PM, revealed privacy curtains and window blinds should be closed and the resident covered to provide privacy during care. An interview with NASR #2, on 07/22/10 at 2:40 PM, revealed she stated, " To provide for privacy the door had to be shut, to pull the curtain, and put gloves on with care".  A review of the facility's policy and procedure for "Body Audit", dated 03/11/10, revealed the licensed nurse was to ensure provision of privacy for the resident. A review of the facility's policy and procedure for, "Wound Care", dated revised, on 03/09/10, revealed the door should be closed, the privacy curtains pulled and the window blinds should be closed, if applicable.	F 164		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F tag: 280  1. Corrective action: Resident # 11— Care plan revised by acting Social Services Director on 8-4-10, to include sexually inappropriate behaviors and interventions.	

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F 280	<p>Continued From page 4</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a care plan was revised for one resident (#11), in the selected sample of 15, after an incident of sexually inappropriate behaviors. Findings include:</p> <p>A record review revealed Resident #11 was admitted to the facility, on 04/11/02, with diagnoses which included Bipolar I Disorder and Dementia with Behavior Disturbance.</p> <p>A review of the quarterly MDS assessment, dated 07/14/10, revealed the facility identified Resident #11 as severely cognitively impaired.</p> <p>A review of the resident's care plan, dated 10/14/09, revealed the resident exhibited socially inappropriate/disruptive behavior (e.g. sexually inappropriate behavior/grabbing male and female</p>	F 280	<p>Acting Social Services Director inserviced 8-10-2010 regarding reviewing and revising care plans when there are changes in behaviors noted.</p> <p><i>Item # 2</i></p> <p><b>2. ID of others at risk:</b> A review of all Comprehensive Care Plans for residents exhibiting behaviors was completed by the Social Services Director 8-10-2010 with no other problems identified.</p> <p><b>3. Prevention measures:</b> Acting Social Services Director inserviced by ADM 8-10-2010 regarding reviewing and revising care plans when there are changes in behaviors noted. It is the policy of this facility for every socially inappropriate incident to be reported immediately to the DON and Adm. The DON/ADM then contacts the Social Services Director for psycho-social follow up including reviewing and revising the care plan after any recordable, social-related incident.</p> <p><i>Item # 3</i></p>		

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F 280	<p>Continued From page 5 staff in their private parts).</p> <p>A review of the facility investigation, dated 10/25/09, revealed Resident #11 was observed exhibiting inappropriate behaviors directed at the resident's roommate. The report revealed staff heard Resident #11's roommate yelling from the shared room. Staff responded and observed Resident #11 with his/her arm across the roommate's chest and the other hand under the roommate's shirt. Although, the roommate was moved to another room, a review of Resident #11's care plan, with a revised date of 12/23/09, revealed the facility did not ensure additional interventions were added to the care plan to address inappropriate sexual behaviors directed at other residents.</p> <p>An interview with Licensed Practical Nurse (LPN) # 1, on 07/23/10 at 1:40 PM, revealed Resident #11 was fascinated with breasts, grabbed at staff and him/herself, but had never exhibited the behaviors towards other residents, prior to 10/25/09. She stated the care plan committee met monthly to discuss behaviors and although the care plan included interventions for the resident's behaviors directed at staff and him/herself, the care plan was not revised after the 10/25/09 incident to address behaviors directed at other residents.</p>	F 280	<p><b>F tag 280 Continued</b></p> <p><b>4. Monitor:</b> A review will be conducted monthly by the Social Services Director of the Behavioral Observation Program (BOP), using the BOP CQI tool, which includes the review of the care plan. Data will be presented to the CQI Committee in the monthly meetings. <i>(See Appendix Item 3A)</i></p> <p><b>5. Date Corrected:</b> 8-15-10</p>	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 281	<p><b>F tag: 281</b></p> <p><b>1. Corrective action:</b> Resident # 2— CMT #1 inserviced by the DON on 7-23-10 regarding following physician orders as written. <i>(See Appendix Item 4)</i></p>	

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F 281	<p>Continued From page 6</p> <p>Based on observation, interview and record review, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one resident (#2) in a selected sample of 15. On 07/20/10 at 8:00 AM, during a medication pass Certified Medication Technician (CMT) #1 failed to administer the resident's medication in accordance with physician orders.</p> <p>Findings include:</p> <p>A review of physician's orders, dated July 2010, revealed an order for Ferrous Sulfate 325 mg to be administered with orange juice, orally three times a day. An order, dated 07/19/10, written by the Speech Therapist, revealed the resident's diet included regular liquid consistency for carbonated beverages and all other beverages were to remain a nectar thick consistency.</p> <p>An observation during the medication pass, on 07/20/10 at 8:00 AM, revealed CMT #1 administered the resident's medication (Ferrous Sulfate) with a regular consistency House supplement. Resident #2 was observed to gag once and cough at two different intervals, while consuming the medications and house supplement. Resident #2 told CMT #1 the medication was getting "stuck in his/her throat". CMT #1 encouraged the resident to take slow sips so he/she would not strangle or choke.</p> <p>An interview with CMT #1, on 07/20/10 at 11:48 AM, revealed she forgot to obtain orange juice for the medication administration. She stated she did not add thickener to the house supplement because the supplement was thick without adding the thickener.</p>	F 281	<p><b>2. ID of others at risk:</b> A review of medication pass by CMT #1 was completed by Hall 2 Compliance Nurse on 8-11-10 with no problems following physician orders identified.</p> <p><b>3. Prevention measures:</b> CMT #1 inserviced by the DON on 7-23-10 regarding following physician orders as written. CMT will obtain nectar thicken orange juice and any other special need supplies required prior to beginning any medication pass. <i>(See Appendix Item 4)</i></p> <p>Per the viscosity of the house supplement, this nutrition professional agrees with the nectar thick consistency of the product used to administer the Ferrous Sulfate. RD Consultant agrees. <i>(See Appendix Item 5) - 5A</i></p> <p><b>4. Monitor:</b> A review will be conducted monthly by an Administrative Nurse for 3 months and then quarterly by the Pharmacy Consultant and results reported to CQI team.</p> <p><b>5. Date Corrected:</b> 8-15-10</p>	

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F 281	Continued From page 7 An interview with Registered Nurse (RN) #1, on 07/23/10 at 11:03 AM, revealed she was informed by CMT #1 that the resident's medication had been administered without orange juice, as ordered. She notified the physician regarding the orange juice not being given with the Ferrous Sulfate.  An interview with the resident's physician, on 11/23/10 at 1:07 PM, revealed the facility notified him, on 07/22/10, and informed him Resident #2 did not receive orange juice with the Ferrous Sulfate. The physician stated he expected the staff to administer the medication as ordered.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined the facility failed to ensure services were provided in accordance with the care plans for one resident (#2), in the selected sample of 15. Findings include:  A record review revealed Resident #2 was admitted to the facility, on 09/22/05, with diagnoses which included Dysphagia, Bipolar Disorder, Dementia, Diabetes Type II, Parkinson's Disease, Convulsions, Anemia, Cerebrovascular Accident, Hypertension and Deep Vein Thrombosis.	F 282	F tag: 282  1. Corrective action:  CMT #1 inserviced by the DON on 7-23-10 regarding following physician orders as written. CMT will obtain nectar thicken orange juice and any other special need supplies required prior to beginning any medication pass.  NASR #7 and all NASR's inserviced by Compliance Nurse 8-11-10 thru 8-13-10 regarding supervision of residents requiring texture modifications. (See Appendix Item 4, 6)  Vending machines moved out of the resident area to a locked, restricted, area of the building only available with a code. Snacks are provided and monitored by the facility.	

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F 282	<p>Continued From page 8</p> <p>A review of the quarterly MDS assessment, dated 07/19/10, revealed the facility assessed Resident #2 as moderately cognitively impaired and requiring verbal cues and supervision with eating, to ensure safe meal completion, due to swallowing difficulties.</p> <p>A review of the care plan, dated 07/19/10, for "At Risk for Choking and Aspiration due to Dysphagia" included interventions, "Offer small bites and wait for the resident to swallow. Remind to swallow if needed" and "Monitor for choking on liquids as ordered."</p> <p>A review of the diet order, dated 07/08/10, revealed the resident was to receive a mechanical soft diet with all meats served with gravy. The resident's liquids were to be nectar thickened consistency. A dietary order, dated 07/19/10, revealed the resident could have regular liquid consistency carbonated beverages, but all other liquids remained nectar thickened consistency.</p> <p>An observation during the medication pass, on 07/20/10 at 8:00 AM, revealed CMT #1 administered the resident's medication with regular consistency house supplement. Resident #2 was observed to gag and cough while consuming the house supplement.</p> <p>An interview with CMT #1, on 07/20/10 at 11:48 AM, revealed she did not add any thickener to the house supplement because the supplement was thick without adding the thickener.</p> <p>An observation during the breakfast meal in the dining room, on 07/21/10 at 8:10 AM, revealed</p>	F 282	<p><b>2. ID of others at risk:</b> All residents with po intake determined to be at risk. In a review of all residents by the DON and Compliance Nurses on 7-23 and 24, 2010, no residents have been deemed effected by the deficient practice.</p> <p><b>3. Prevention measures:</b> CMT #1 inserviced by the DON on 7-23-10 regarding following physician orders as written. CMT will obtain nectar thicken orange juice and any other special need supplies required prior to beginning any medication pass.</p> <p>NASR #7 and all NASR's inserviced by Compliance Nurse 8-11-10 thru 8-13-10 regarding the serving and supervision of residents requiring texture modifications. (See Appendix Item 6)</p> <p>Vending machines moved out of the resident area to a locked, restricted, area of the building only available with a code. Snacks are provided and monitored by the facility.</p> <p><b>4. Monitor:</b> A review of residents with texture modifications will be conducted monthly by an Administrative Nurse using the CQI Weight Loss</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/23/2010
NAME OF PROVIDER OR SUPPLIER  DAWSON POINTE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 213 WATER STREET DAWSON SPRINGS, KY 42408	
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F 282	Continued From page 9 staff served Resident #2 a cup of regular consistency black coffee.  An interview with Resident #2, on 07/21/10 at 8:40 AM, revealed he/she obtained and ate foods from the vending machine, located near the dining room. Observation revealed the vending machine contained potato chips, pop tarts, pretzels, cookies, crackers, various candies, chewing gum and snack cakes.  An interview with the Speech Therapist, on 07/22/10 at 3:40 PM, revealed she had concerns about the resident being served coffee, but had no concerns regarding the resident eating foods obtained from the vending machine, as long as it was diet appropriate.  Interviews with CMT #2 and Nurse Aide State Registered (NASR) #7, on 07/23/10 at 9:45 AM and at 10:10 AM, revealed Resident #2 required supervision while eating but could feed him/herself. The staff were supposed to check the diet card at each meal. CMT #2 and NASR #7 had observed Resident #2 go to the vending machine, but did not know what the resident got from the machine.  Interviews with RN #3 and Licensed Practical Nurse (LPN) #1, on 07/23/10 at 10:30 AM and at 1:20 PM, revealed the resident could feed himself/herself and was supervised during meals. The resident's use of the vending machine was not monitored and due to the fact the resident was alert and oriented, he/she could go to the machine at any time, if he/she had the money to do so.	F 282	Prevention Tool (includes monitor for modifications) for texture modifications for 3 months and then quarterly. Results will be reported to the CQI Team. <i>(See Appendix Item 7)</i>  5. Date Corrected: 8-15-10	
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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F 364	<p>Continued From page 10</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to store, prepare and serve food under sanitary conditions, related to inadequate food temperatures, lack of calibration of thermometers and maintaining proper sanitation.</p> <p>A review of the Census and Conditions form, dated 07/20/10, revealed the facility census was 59. It was determined 58 of 59 residents were served food that was stored and prepared in the facility kitchen. Finding include:</p> <p>Observations during the trayline service, on 07/20/10 at 6:10 AM, at 12:05 PM and on 07/21/10 at 6:40 AM, revealed the following food temperatures:</p> <p>Oatmeal, 106 degrees Fahrenheit (F) Pureed eggs, 124 degrees F Seven (7) Fried eggs, 78 to 98 degrees F Milk, 54 degrees F Thickened Milk, 50 degrees F Cottage cheese, 50 degrees F Pudding milk, 40 degrees F Thickened Water, 52 degrees F Coffee at 88 degrees F</p>	F 364	<p>F tag: 364</p> <ol style="list-style-type: none"> <li><b>Corrective action:</b> RD immediately inserviced Dietary staff, 7-20-2010, regarding temperatures, calibrating thermometers and sanitation, including the proper serving and storing of food. <i>(See Appendix Item 8)</i></li> <li><b>ID of others at risk:</b> All residents with po intake determined to be potentially at risk. In a review of all residents by the DON and Compliance Nurses on 7-23 and 24, 2010, no residents have been deemed effected by the deficient practice.</li> <li><b>Prevention measures:</b> RD immediately inserviced Dietary staff, 7-20-2010, regarding temperatures, calibrating thermometers and sanitation, including the proper serving and storing of food.</li> </ol> <p>Follow up inservice trainings on Food temperature and sanitation requirements and the calibration of thermometers were held by the Food Service Director on 8-11-2010. <i>(See Appendix Item 9, 10)</i></p> <p>Daily compliance rounds for sanitation in Dietary initiated by the Food Service Director on 8-10-2010. <i>(See Appendix Item 11)</i></p>	

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F 364	<p>Continued From page 11</p> <p>Observation and interview with the dietary staff, during the observations, revealed staff obtained food and fluid temperatures 55 minutes prior to the start of the tray-line and estimated the mid-point of service temperatures of the food items. In addition, the dietary staff did not use a calibrated thermometer.</p> <p>An interview with Cook #1, on 07/20/10 at 6:16 AM, revealed the digital thermometer used by the facility was not calibrated and registered a temperature of 43.3 degrees F, when placed in ice water. The cook stated mid point food temperatures were estimated. The cook was knowledgeable of required temperatures for hot and cold foods.</p> <p>An interview with the Dietary Manager, on 07/20/10 at 7:03 AM, revealed she was not aware the dietary staff were taking food temperatures 55 minutes prior to serving the meals and estimating some food temperatures. She was not aware thermometers were not calibrated or assessed for accuracy.</p> <p>An interview with Cook #1, on 07/20/10 at 6:40 AM, revealed the Dietary Manager was "never there to watch breakfast" and dietary staff had been "serving breakfast that way for 13 years and never had a problem."</p> <p>An interview with the Dietary Manager, on 07/20/10 at 7:03 AM, revealed her usual working hours were 8:00 AM until 5:00 PM. She had been employed in the position for four months. She did work the breakfast shift at times when the cook was on vacation, but she did not routinely monitor the breakfast meal for temperatures.</p>	F 364	<p><b>4. Monitor:</b></p> <p>Daily Compliance Rounds Monitoring tool will be reviewed by the Dietary Manager daily.</p> <p>The CQI Dietary Tool for Departmental Audits and Sanitation will be reviewed monthly by the Dietary Manager or the RD for 12 months. Any problems found will be corrected immediately and results will be reported to the CQI Team monthly. (See Appendix Item 12)</p> <p><b>5. Date Corrected:</b> 8-15-10</p>		

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F 364	Continued From page 12 An interview with the Dietician, on 07/20/10 at 8:12 AM, revealed she audited several test trays on the lunch and supper meals, but had not monitored the breakfast meal. The Dietician stated the hot foods should not leave the tray-line at less than 135 degrees F and the cold food at no more than 41 degrees F.	F 364		